

# APPENDIX

# Methodology

2018 MINNESOTA HEALTH CARE DISPARITIES  
BY RACE, HISPANIC ETHNICITY, LANGUAGE  
AND COUNTRY OF ORIGIN

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[mncm.org](http://mncm.org)

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# METHODS

The measures in this report use data reported to MNMCM directly from clinics. Most of these Direct Data Submission (DDS) measures are developed and maintained by MNMCM.

## Data Collection

Data submission requirements are specified by MN Community Measurement in our 2018 DDS guides. These guides provide detailed steps and instructions to ensure clinics submit data in a standard format.

In this report, data are reported by medical group. Medical groups usually consist of multiple clinics. Often, the medical group provides centralized administrative functions for multiple clinics.

Clinic abstractors collect data from medical records either by extracting the data from an electronic medical record (EMR) via data query or from abstraction of paper-based medical records. Medical groups complete numerous quality checks before data submission. Detailed instructions for medical groups/clinics conducting quality checks are provided in the 2018 DDS Guides. All appropriate Health Insurance Portability and Accountability (HIPAA) requirements are followed.

MNCM staff conduct an extensive validation process including pre-submission data certification, post submission data quality checks of all files, and audits of the data source for selected clinics. For medical record audits, MNMCM uses NCQA's "8 and 30" File Sampling Procedure, developed in 1996 in consultation with Johns Hopkins University. For a detailed description of this procedure, see [www.ncqa.org](http://www.ncqa.org). Audits are conducted by trained MNMCM auditors who are independent of medical groups and/or clinics. The validation process ensures the data are reliable, complete and consistent.

## Eligible Population Specifications

The eligible population for each measure is identified by a medical group on behalf of their individual clinics. MNMCM's 2018 DDS Guides provide technical specifications for the standard definitions of the eligible population, including elements such as age.

## Numerator Specifications

For DDS measures, the numerator is the number of patients identified from the eligible population who meet the numerator criteria. The criteria are specified by MNMCM in the 2018 DDS Guides and technical specifications. Clinical quality data the medical group submits is used to calculate the numerator; this data is verified through MNMCM's validation process.

## Calculating Rates

Due to the dynamic nature of patient populations, rates and 95 percent confidence intervals are calculated for each measure for each medical group/clinic regardless of whether the full population or a sample is submitted. Rates are first calculated for each medical group/clinic and then a statewide average rate is calculated. The statewide average rate is displayed when comparing a single medical group/clinic



to the performance of all medical groups/clinics to provide context. The statewide average is calculated using all data submitted to MNCM – this includes data primarily from Minnesota clinics but may include some data from clinics located in surrounding communities.

## Thresholds for Public Reporting

MNCM has established minimum thresholds for public reporting to ensure statistically reliable rates. Only medical groups and clinics that meet these thresholds are reported. For DDS measures included in this report, a minimum threshold of 30 patients per medical group is required.

## Race, Hispanic Ethnicity, Language, and Country of Origin Analyses

For the nine DDS measures, the race, ethnicity, language, and country of origin data is submitted by medical groups through MNCM’s DDS process. Please refer to the MNCM *“Handbook on the Collection of Race/Ethnicity/Language Data in Medical Groups”* for more information about this data.

## Best Practices for Clinical Quality Measures

Race, Hispanic ethnicity, language, and country of origin data collection undergoes a unique validation process to ensure that medical groups collect these data elements from patients using best practices. Best practices are defined as:

1. Patients self-report their race and Hispanic ethnicity
2. Patients have the option to select one or more categories for race (i.e., medical groups/clinics do not collect data using a multi-racial category).
3. Medical groups/clinics have the ability to capture and report more than one race as reported by the patient.

A medical group/clinic must meet all the criteria for each data element to achieve best practice status and to have their data included in the rate calculation. Only validated data, collected using best practices, are used to calculate rates by race, Hispanic ethnicity, language, and country of origin.